District Nursing

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ONE SHILLING

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District Nursing

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Editorial

THE article in our August issue (page 111) by Sir Charles Hambro advising nurses to safeguard their superannuation rights has aroused such considerable interest that it is being reprinted in leaflet form for the guidance of those who would like to extend the scope of their nursing experience, but are held back through the fear of having to lose their pension rights.

Following this, Sir Geoffrey Church, Chairman of the Federated Scheme for Nurses and Hospital Officers referred to in the article, has explained how this scheme can accept the transfer of benefits.

Nurses who wish to go overseas, for example, can have not merely the amount of their own contributions, but all benefit earned under the National Health Service or a local authority scheme, transferred to the F.S.S.N.; and provided their nursing career continues for five to ten years, they will be assured of the full value of the benefit. The benefit, incidentally, can be transferred neither to the nurse herself nor the overseas authority to which she is going, but only to the F.S.S.N.

At present experience shows that the great majority of nurses, medical ancilliaries and hospital officers taking up nursing employment overseas—or in industry, or in private practice—do not realise they can preserve the benefits towards pension that they have earned in statutory employment.

Those planning to leave public service but continue in nursing are therefore strongly advised to seek advice from the Federated Scheme at Rosehill, Park Road, Banstead, Surrey, before accepting any return of pension contributions.

As Sir Geoffrey Church said: " Nurses and others in kindred professions should be superannuated for their service in their professions and not merely for service in one particular employment."

Perhaps it may seem strange that we whose interests lie in the public health services should be offering advice that may help a nurse to leave that service. We are not, of course, advocating that she should do so; but our concern lies also with the personal interests of nurses both at home and throughout the world.

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Salary status of pupil midwives
. . . Working a 44 hour week.

Press Gallery Notebook

from our Parliamentary Correspondent

THE salary status of pupil midwives is explained by the Parliamentary Secretary to the Ministry of Health in a letter he wrote on July 9th to Mr. R. Gresham Cooke, Conservative M.P. for Twickenham, who received the following letter of complaint from a male constituent:—

" Student nurses, when they have passed as S.R.N., usually proceed to a further course such as midwifery, in which case I understand their meagre salary is reduced to that of unqualified nurses.

"As their professional skill is made use of during such a course, it does seem a paltry and unjustified economy, as several nurses I know personally also think. If you agree, I shall be much obliged if you would kindly bring this matter to the attention of the Minister of Health."

The Parliamentary Secretary, replying to Mr. Cooke's request for his observations on this constituent's letter, writes:—

"All women undergoing midwifery training are regarded and paid as pupil midwives during the course, whether or not they are already trained nurses. Those who are registered nurses get £27 more per annum than those who are not, but it does, of course, mean that a trained nurse who leaves her employment to become a pupil midwife suffers a substantial reduction in remuneration.

These arrangements have been in force for a long time and have been agreed to by both sides of the Nurses and Midwives Council, who are responsible for determining the remuneration of nursing and midwifery staff.

The present arrangements are no deterrent to nurses wishing to undergo midwifery training since, in fact, the numbers coming forward for training are more than sufficient to meet the needs of the midwifery profession. It is unfortunately true that not enough of them go on to practice midwifery when trained, but that is not due to any shortage of pupils."

44-Hour Working Week with No Extra Staff

To what extent is it anticipated that the 44-hour working week for nurses, now being implemented in hospitals, will result in an increase in hospital nursing staffs?

This question was put in the House of Commons on July 14th to the Minister of Health by Mr. Reginald Sorensen, M.P., for Leyton, who specialises in hospital adminstration and the welfare of the nursing profession.

" I hope ", replied the Minister (Mr. Derek Walker-Smith), that it will be possible to make considerable progress in the shortening of working hours by reorganising the work of the nurses and midwives, without any substantial increase in numbers of staff. I am sending the hon. member a copy of a memorandum sent to hospital boards and committees on this matter.

Mr. Sorensen: Has the Minister any evidence whatever of dislocation or difficulty arising out of this very desirable limitation of reduction in working hours?

Mr. Walker-Smith: No, sir. The recommendation of the Nurses and Midwives' Whitley Council was conveyed to hospital authorities on 10th June asking that these hours should be reduced in this way as soon as conditions permit, having regard to the availability of staff and subject always to the requirements of the service. I am very hopeful that the reduction will be achieved without any necessity of increased staff, and certainly without detriment to the service.

Mrs. Elizabeth Braddock (Labour—Liverpool Exchange): While the staffs are satisfied with the suggested reduction in hours, is the Minister aware that the fact that his circular tells management committees that they will not be permitted any increase in the money that it allowed to them, if they recruit additional staff, is making the position very difficult for those responsible for administering the hospitals?

Mr. Walker-Smith: I do not think it should make it difficult because, as many surveys of the nursing services have shown, there is ample scope for re-organisation of the duty rosters and other methods of rationalisation which should shorten hours without the addition of staff or the loss of efficiency.

Mr. A. Blenkinsop (Labour—Newcastle-upon-Tyne E.), a former Parliamentary Secretary to the M.o.H.: Would the Minister not agree that there are some cases at least in which an increase in nursing staff is urgently necessary?

Mr. Walker-Smith: Yes, but those cases must be looked at in the individual context and not as part of a consequence of a general reduction of hours such as this.

R.S.H. FELLOWSHIPS

A member of the Queen's Institute Council, Dr. Joseph A. Gillet, Medical Officer of Health, Dagenham, has been made a Fellow of the Royal Society of Health. Other R.S.H. Fellowships, conferred in recognition of noteworthy public health work, include Mr. George L. C. Elliston, M.A., Editor of the Journal of the Society of Medical Officers of Health, *The Medical Officer*.

From the address by the Professor of Human Ecology, University of Cambridge, to a refresher course for district nurses and health visitors

The Changing Pattern of Medical and Nursing Care

by A. LESLIE BANKS, M.A., M.D., F.R.C.P., M.R.C.S., D.P.H.

IT is worthy of note that among the principal subjects chosen for discussion at this course are recent trends in mental deficiency, health education and its teaching, psychology and psychiatry with particular reference to the family, and preparing for old age. These are very different from the traditional interests of district nurses, midwives, and health visitors, and they are significant of the changes now occurring.

I like to begin with conditions as they were a hundred years ago. Dr. William Farr, in his letter to the Registrar General for 1858, drew attention to the "chief fact of all" namely, that of 449,656 people who died, 440,922 left some record of that fatal illness.

Accurate medical certification was still in its infancy, but the statistics then available are in striking contrast to those of today. The death rate, for example, was twenty-three per thousand as compared with approximately eleven at the present time, and twenty-five per cent. of all deaths were due to infectious diseases.

In that relatively small population of nineteen and a half million people there were thirty thousand deaths from scarlatina and diphtheria as compared with the small handful of deaths from these diseases at the present time. Some 6,500 deaths were due to smallpox, 9,000 to measles, 11,000 to whooping-cough, 18,000 to "typhus" and over 14,000 to diarrhoea and cholera.

There were over one thousand deaths from syphilis, mainly congenital, whereas today no deaths occur from congenital syphilis. The total number of mothers who died from child-bearing was 3,131, ten times as many as today although the population is more than double. In Yorkshire ten people in a hundred died without medical attendance of any kind in 1858 and in Wales twelve out of every hundred died without medical care.

It was a matter of congratulation at that time that seventy-three per cent. of men and sixty-two per cent. of women could write their own names. The birth rate was still high, at 33·5 per thousand, whereas today it is less than one half of that figure. Nearly a million people were on Poor Law relief of fourpence a day.

The principal channels for the diffusion of sanitary knowledge, as it was called, were the medical practitioners, the public writers, lawyers, clergy, and gentry. There was, you will notice, no mention of district nurses, midwives, or health visitors, for the simple reason that they did not exist, although in 1854 the comment had been made that many of the remaining dangers to health would be removed by a class of educated nurses.

It was already being noted at that time that pulmonary diseases, such as bronchitis and pneumonia, were three times as fatal in London as in Wales. Many deaths were attributed to impure air in cities, but "the greater part of the evils from which country people are now suffering is the result of ignorance."

So much for the past. Where do we stand now? There are, in England and Wales, some forty-five million people, of whom those under the age of fifteen and over the age of sixty-five are nearly equally balanced. The expectation of life from birth has risen to about sixty-nine for a male and seventy-four for a female, and the principal causes of death are those found in later life, cardio-vascular disasters, cancer, diseases of the respiratory system, and accidents, poisoning, and violence.

In other words, we now face a totally different set of problems. We have to deal with the killing diseases of later life, with the degenerative diseases of older people, with the virus diseases, and, above all, with the medico-social problems of dense industrial communities.

On the other hand we can meet these new problems with totally different weapons from those of our forefathers, for we are well equipped with laboratories, with all the new advances in therapy including the antibiotics, and with trace elements and the many other resources of modern physics and chemistry. In addition we have highly organised medical services.

Some changes are already apparent. The emphasis of the work in hospitals is shifting away from the wards to the out-patient departments where much of the diagnosis and treatment is carried out. Increasing emphasis is being placed on domiciliary care, both for mental and physical disorders, while the general medical practitioners are now tending to practise in groups. The older type of single-handed practice is becoming relatively rare.

There are now some ten thousand district nurses in England and Wales, approximately five thousand of whom are also engaged part-time in midwifery and health visiting, and they pay about twenty-five million visits each year. Over half of these visits are to old people.

The seven thousand domiciliary midwives conduct about two hundred and fifty thousand confinements each year, and the six thousand health visitors pay some eleven million visits.

What are the possible changes to be expected in the future? There has been a decline in domiciliary midwifery which now amounts to thirty six per cent. of the whole, and I cannot visualise a reversal of this trend.

Psychiatric Aspects of Preparing for Old Age

by RUSSELL A. PARGITER, M.B., B.S., D.P.M.

Assistant Psychiatrist Fulbourn Hospital, Hon. Assistant Psychiatrist Addenbrooke's Hospital, Cambridge.

AGEING is a natural process involving complex physical and mental changes which are far from being understood. The degeneration which goes on in all the body cells is a natural process, but may well step beyond the bounds of normality if it is unduly rapid or affects one kind of tissue more than another. These degenerations or ageing processes are often most marked in arteries and the central nervous system which of course includes the brain. Thus mental symptons are common in old age.

In addition, occurring simultaneously with these physical changes are psychological changes, often of a gradual and subtle kind. As people grow older their interests, attitudes, temperaments and sentiments change. There is an increasing conservatism, perhaps an inflexibility of outlook and inability to accept new ideas. There is a tendency to look back rather than forward. These changes are extremely variable, and largely depend upon the personality of the individual involved.

All these things are part and parcel of the ageing process.

Next we must ask ourselves if psychiatry which is that branch of medicine dealing with mental illness can help us to prepare for old age? I think it can, because psychiatrists find themselves in the position of having to care for and treat a large amount of mental illness occurring in the elderly.

For various reasons mental illness reaches a peak in old age. One is simply the fact that owing to modern medical treatments people are living longer. The proportion of the aged in the population is increasing, so there is a greater number at risk. Apart from this, why is there such a lot of mental illness in the elderly?

The causes of mental illness can be explained under three headings: i Organic or Physical; ii Psychological or environmental; iii Constitutional.

All three causes are generally operative in any one case but one of them usually predominates.

Examples of organic causes are arteriosclerosis, senile dementia, in which brain cells decay and die, cardiac failure and, despite what we sometimes like to think, malnutrition, which includes vitamin deficiencies.

Psychological causes can be the loss of a spouse, relative or friend. The feeling of not being wanted, retirement, disappointments and unexpected changes all come under this heading.

In dealing with the constitutional causes we are on less certain grounds. Most authorities believe many people have an inherited predisposition to certain forms of mental ill health, such as maniac depressive psychosis in which periods of depression alternate with periods of excitement and over-activity. Between these periods there are often long intervals of normality. Such an illness may be a feature of a person's life from early middle age but relapses are common in old age.

As I have mentioned, although two or all three of these causes contribute to a breakdown in mental health, one usually predominates. For instance, narrowing of the cerebral arteries may release a tendency to a constitutionally based psychosis. Malnutrition and arteriosclerosis, perhaps coupled with a mild broncopneumonia, may result in a confusional state in which the patient is lost, agitated and hallucinated. An arteriosclerotic patient may be able to cope well until losing his or her spouse. The natural grief and inability to adapt to the changed conditions may result in depression with suicidal attempt.

In the causes of mental illness in old age the organic and physical predominates. Next in importance are the environmental and psychological changes; and last are the constitutional changes.

continued opposite

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In the second place there is an increasing amount of work required for the elderly and less for the young.

Thirdly, and very important, is the attention which is now being paid to "the family," for various reasons. Included among these are the relationship of juvenile delinquency to broken homes in many cases, the fact that a great number of accidents in the home are preventable by education of the family, and the belated realization that the mental stability of any community depends to a very large extent on the health and welfare of the families of which it is composed.

One thing is clear. It is no longer possible for any doctor or nurse to work in isolation. Changes are taking place too rapidly for this and the whole tendency is to close the ranks and work as a team.

This means that we must work towards the unification of hospital and domiciliary medical and nursing care, with the out-patient departments as the focal point of these services. At the same time we must encourage all concerned with the care of people in their own homes to work together more closely.

Indeed, I suggest there is a strong case for bringing all personal health services under a unified administration, or, if that is not possible, to organise their practical working from one principal centre in each area which is in close touch with those engaged in domiciliary practice. This may sound a counsel of perfection, but it is, I believe, the ideal at which we must aim.

In our present state of knowledge we cannot halt or reverse the natural or pathological processes of ageing. We cannot stop arteriosclerosis or the inexplicable decay and death of brain cells which occur in senile dementia. We can however often alleviate the worst effects of such changes. If a patient has a cerebral circulation impaired by arteriosclerosis then a failing heart may reduce the level of cerebral circulation below normal so that mental symptoms appear. Treatment of the cardiac condition may restore the normal balance of that person's mind.

When there is malnutrition, adequate diet, vitamins and especially fluids will often restore an elderly patient with a mental breakdown. Adequate diet, fluid, and vitamins are essential in the prophylaxsis of mental breakdown because the elderly brain is physiologically less flexible, has a smaller safety margin, and is therefore much more easily upset than the brain of a younger person. Thus slight dehydration which would produce no effect in a young person may produce florid mental symptoms in an elderly person. In fact many of the acutely disturbed elderly persons admitted to Fulbourn get better very quickly as a result of ordinary nursing procedures in which special attention is directed towards adequate fluids, easily digested food and vitamins coupled with sedatives and tranquillisers if necessary. Of course we exclude treatable physical ailments either in the circulatory, respiratory and alimentary systems. Often enough these patients need never have come into hospital if they had been adequately cared for in their homes, but loneliness, apathy, neglect, and ignorance result in breakdown and admission to hospital. Education of old folk about their diet and the ' meals on wheels' service are both excellent preventitive measures which can be considered as a part of preparing for old age.

Now let us consider the prevention of mental ill health which is due to psychological or environmental causes. Many old people are lonely—perhaps because they have never made friends or because they have lost them. Obviously loss of a spouse is a main cause. There are subsidary reasons for loneliness such as the disinclination of the younger generation to have their aged relations live with them. This is not always unreasonable in these days of small houses and housing shortages. There is also frequently a clash between the young and the old living under the same roof, and the feeling in the aged of not being wanted may be increased by their conflicts. If the elderly can live at peace with his or her relations all well and good. They are more likely to succeed if they can be of some use in the household and have interests outside it.

If the elderly cannot live alone or with relatives, a solution may be found in an old people's home, but this is not always the best way out. Old people often value their independence and rightly so. They do not want to be parted from their familiar furniture and treasures. The ideal arrangement is the small bungalows and flats for the aged which are a feature of some modern housing estates. Here the elderly person has the best of both worlds. They are in a community, probably near their younger relatives, yet are independent. Alms houses have a great deal to be said for them insofar as they offer privacy, independence with some degree of community life, and friendly help and supervision.

A proper pattern of social life is necessary for most elderly people. The Darby and Joan clubs are extremely useful in preventing loneliness and widening horizons. So useful are they from the prophylactic psychiatric point of view that we run one for our patients at Fulbourn

Retirement of men at the age of 60 or 65 is often a powerful cause for mental ill health. The experiment in setting up workshops for the elderly in some industrial areas is an excellent preparation for old age. In these workshops the skills and experience of craftsmen are still used, but the tempo is slower and the accent on quality rather than quantity. Social life is encouraged in these workshops and the atmosphere is more like a club. In this way the old men can feel useful, earn money, combat loneliness, and their skills and experience are not wasted.

Importance of Hobbies

The importance of hobbies and interests outside work cannot be overstressed. They give the retired man something to fall back on so that his life after retirement is not empty and devoid of interest. Many old people of course retire from one job and take up a lighter one or a part time job. Others devote a lot of their time to the public good—serving on committees and doing voluntary work. This is very laudable both from their point of view and that of the community. Most people prepare for old age without consciously thinking about it, and settle into one or other of the patterns I have mentioned. In fact many old people do not admit to being old and it seems that old age so to speak creeps up on them and takes them unawares. However as the time for a less active life approaches, a little advice may be helpful.

The natural tendency is to look back over one's life, reviewing one's achievements. If one has no achievements then it may look a little bleak. Thus one can say that part of the preparation for a contented old age is a worthwhile job or spare-time activity. The seeds for happy old age are to a large extent sown in the middle years. The contentment of having raised a family is a considerable one—although I hasten to add that I do not advise the raising of large families merely to give contentment in old age.

Summing up, the psychiatric preparation for old age involves proper care of physical health, and prompt attention to alleviate the effects of physical degeneration. Environmental and psychological preparation involves the maintaining of healthy interests and activities together with integration into some pattern of community life. If more attention could be paid to these matters I am sure that the incidence of mental ill health in the aged would fall.

The paper by the Medical Superintendent and Consultant Psychiatrist, Little Plumstead Hospital, Norfolk

Recent Trends in Mental Deficiency Practice

by J. V. MORRIS, M.A., M.D.

IN dealing with mental defect, I think it is necessary to accept the fact that severely handicapped children suffer, as a rule, from irreversible lesions. Much work has been done in this respect by Kirman. The present approach adopted by many research teams is a chemical one. One of the most promising aspects of the work emerges from an investigation of phenylketonuria, which is not uncommon and is as definite a clinical entity as mongolism. Claims have been made by some research workers that it is possible to detect carriers for this condition by using phenylalanine tolerance tests. They state that recessive genes are present in affected individuals which produce a single enzyme effect and the result is that treatment gives considerable improvement.

Many other diseases of the clinical entity type also appear to show faulty metabolism. Among these Cretinism, Wilson's disease, galactosaemia, and hypoglycaemia. Others such as gargoylism, Lawrence Moon Biedl syndrome and retinitis pigmentosa are also sometimes associated with metabolic errors. Much experimental work is being done in connection with these disorders of metabolism since the new process of electrophoresis has been made available to research workers. The major aspect of general research, however, is directed to the study of phenylketonuria. Various treatments have been adopted for it and the results are extremely promising.

A considerable amount of work has been done by various workers in the field of cerebral stimulants. Amphetamine and its derivatives have been tried, vitamin B complex and other alleged cerebral stimulants have been given fairly consistent trials. The results, however, have not been very encouraging.

Tranquillizers have been found of considerable value in the treatment of disturbed defectives, and sometimes as a preliminary to psychotherapy with the higher grades. Electro-convulsive-therapy has been a standard practice for those with mild surpadded psychosis.

Surgical procedures also are being attempted on a much larger scale in cases of severe epilepsy. Hemispherectomy has been attempted with very considerable success, especially with those with the primary epileptic focus in one hemisphere of the brain. The result of the operation usually tends to produce an improvement in the mental condition of the individual together with a complete relief from epilepsy.

Research in the prevention of mental defect is still in progress. Much of this develops from the study some years ago which indicated that the foetus could be subjected to most severe damage in cases of maternal rubella during early pregnancy. However, it is a fortunate thing that the majority of young people do contract this infection. Indeed a doctor has been known to expose his female offspring deliberately to infection of rubella because of his fear that when they come to motherhood they might contract the disease and thereby give birth to mentally defective offspring.

Many authors suggest that other virus diseases, such as mumps, in pregnant mothers may be responsible for the production of defective children. Work has actually been done in Cambridge whereby it has been proved that in rabbits there is a relationship between the incidence of hydrocephalus and a shortage of vitamin A. Whether this can be related to human beings is doubtful in view of the fact that during the German occupation, especially of the Netherlands, pregnant women were subjected to grossly deficient diets and yet there was not an abnormal amount of hereditary defects among the children born to them. RH. factor incompatability is also being cited as a probable cause of defect and certainly prematurity is associated therewith.

Considerable thought has been given to the dangers of exposing pregnant women to deep X-ray therapy in the abdominal region and over-frequent radiology is considered to be a very bad thing. On the other hand, a survey of Japanese children whose mothers had been exposed to an atomic explosion at Hiroshima in 1945 showed that the incidence of defect among children born to these women was not abnormal.

Ante-Natal Care

Ante-natal care would appear to have a considerable role in prevention of defective birth. Trauma has been for years recognised as a most serious potential cause of defect in children and it cannot be over-emphasized that good ante-natal supervision and ante-maternal training will offer, or should offer, a reduction in neonatal morbidity. Work is at present in progress to estimate what effect on birth injury can be produced by the new techniques with natural childbirth.

Another investigator has proved that eclampsia may result in defective children and it has always been known that attempts at abortion on the part of the mother have often resulted in foetal damage which may, in turn, produce defective children. The work of the research team has now widened and all sorts of different agencies are working on the problem of the congenital nature of defect. The biochemists, the geneticists, the paediatricians and the endocrinologists all have their part to play

and it is to be hoped that when more time and money is available, much valuable information will be brought to light.

In-patient treatment of mental defectives has shown a considerable improvement in the last few years. In the field of training, of the lowest grades particularly, much time and effort has been devoted to the improvement of their general behaviour, especially in social habits. We have found, for example, at Little Plumstead that in feeding the lowest grades of defectives, especially those with cerebral lesions resulting in severe spasticity and who are confined to bed, the usuage of ordinary absorbent paper napkins instead of the traditional bib when feeding is not only cleaner but also avoids facial skin infections.

We use 17 inch material made by Cresco which is laid tucked in under the chin with an ample margin for wiping the face and cleaning the patient up after feeding. The usage of traditional handkerchiefs for these children is out of date. The only suitable method of wiping running noses is to use disposable tissues which can be burnt. These children normally cannot blow their noses and the presence of muco-pus is unpleasant and a source of discomfort to the child, and also a source of skin infection.

Spastics and Deafness

Much research has been done into hearing and I recommend the work of Grace Woods in this respect. She has found that many spastic children, including not only defectives but many who have previously been considered to be much more defective than they actually are, suffer from a variety of deafness. For example, Icterus neonatorum tends to cause high tone deafness. This has been clearly demonstrated by audiometry. The fitting of hearing aids to these children, especially now that transistor aids are available, has enabled them to develop by contact with their surroundings, to a much greater degree than ever considered possible. With this particular group a considerable amount of success has been achieved.

The habit-training of the ambulant low grades has been especially interesting work. Where these patients can be encouraged to walk, or given such physiotherapeutic treatment as they need, they have been adequately trained in sphincter control and only occasionally have lapses of good manners.

Much remains to be done in training these young people in the simple occupations that will provide satisfaction and happiness, instead of allowing them to sit about inert all day.

In the higher grades—especially the feeble-minded adolescents and young adults—we have been engaged on an interesting experiment. In August, 1956, we completed at our hospital a special villa for forty patients of the type who came before the courts. To date no less than 102 patients have passed through this villa. The results have been most encouraging. In the first nineteen months, out of a total of 108 patients nearly all of whom were admitted from the Courts or from prison under Sections 8 and 9 of the Mental Deficiency Acts, nine were discharged and are living happily in the community, four are on licence, and fourteen have been transferred to a hostel branch. The rest with the exception of the residue 35, have moved on to open wards.

This rather rapid re-socialization has been built on the system, not so much of a rigid discipline but as a planned day. Patients admitted to this unit, are made fully aware of the fact that they have offended against the social code. They are advised that they will remain in this unit and live a planned and ordered life until such time as they have mended their ways and accepted advice, and when this happens they will be transferred to more open accommodation.

The essence of the building is based on security because, being secure and escape-proof, the patients no longer devote most of their time to deciding how to abscond from the hospital and what difficulties they are going to create. On the other hand it is very far from being a prison. It is very well designed and equipped with television, billiards, darts and all the normal things that young men enjoy. At the same time misbehaviour is met by firm disapproval rather than punishment. As a further experiment we have found that as many of these people are very illiterate, the development of classes in the " three R's " has attracted an enthusiastic response from the young men, many of whom were grossly retarded and barely able to read the simplest words even though their mental ages were reasonably high.

In addition patients go from this ward to various training departments and return to it in the evening, and we are experimenting with granting parole to selected patients. There will of course always be a small hard core of six to eight difficult psychopaths or homosexuals who will have to remain, but the unit is so designed that they cannot interfere with the normal life of the other patients.

Review of Cases

Another and most interesting factor that has come into prominence has been Circular 58 (3) of the Board of Control. This recommended that all cases should be reviewed with a view to ascertaining how many would remain in hospital of their own free will if discharged from the Acts; and how many parents and relatives would be willing for their children to remain in hospital if the legal formalities of detention were dispensed with. A large survey resulted. We have on our books approximately 1,100 patients, and although we have normally 40 to 50 patients on licence from the hospital in their homes or in employment, it meant making a survey of approximately 1,050 patients.

The results are most interesting. We felt that in starting the survey we must first consider cases with criminal records, especially those recently admitted to hospital. Although it was obvious that if discharged from the restrictions of the Acts they would take their leave and continue to commit social depredations on society, we

excluded from discharge all those who had been convicted through the Courts for acts punishable by imprisonment. These amounted to roughly 200.

We then dealt with the balance. Approximately 85 per cent of our patients have been recommended for discharge from the Acts and have expressed their willingness to remain, or if they were of comparatively low grade and incapable of making a valid decision on their own behalf their parents have answered for them. So far 520 patients have been discharged by the Board of Control who naturally will only issue discharge notices on receipt of advice from the hospital. We anticipate that between 80 and 85 per cent of our patients will be discharged formally from the acts before the end of the year. Only four patients of the first 515 were removed by the parents who seemed to become suddenly aware of the fact that they could have their children home. They had made no applications before and, indeed, if they had asked, the children would have been sent home on request. The old slogan that the child is " put away " in mental dificiency hospitals is a thing of the past.

Short Term Admissions

The practice of taking in patients on a temporary basis to the hospital began in East Anglia, and spread to the rest of the country in 1952 when it was authorised by the Ministry of Health. As a normal procedure we used these short term admissions, which may be up to two months, for a specific purpose:

i To solve an immediate family situation when a family disaster has developed, such as in-patient admission of the mother to hospital or pregnancy of the mother and so forth;

ii For observation of the child and diagnosis, advice, very often in the case of epileptics for balancing on anti-convulsants with a view to assisting the general practitioner in the treatment of the child;

iii To give harassed parents a long needed rest, and to allow them to have a normal holiday which is not always possible especially if the defective is a low grade;

iv For an occasional operative procedure such as T's and A's, dental anaesthetics and others where the child is not suitable for admission to the wards of an ordinary children's hospital.

During 1957 we had 176 admissions of this type, but I do not think the period of two months is long enough. Very often the hospital treatment has brought considerable improvement and made the child more acceptable in the home, even to the extent of having its name removed from the waiting list for admission. Two months is too short for this procedure, however; but it may well be that in years to come admission to a mental deficiency hospital for one or two years will prove sufficient to train the child to be more acceptable and less of a nuisance and difficulty in its home. After all, the proper place for the child is in its own home within its own family group. No hospital can be a substitute for maternal affection.

Diagnosis of defect is not always an easy matter, and in some areas there is unfortunately a shortage of Medical Officers of Health who have knowledge and experience of this matter. We who specialize in this work find that it is increasingly necessary to see children as early as possible. Research is being undertaken into the abilities of pre-school children with the object of detecting the less obvious forms of defect early in life.

Out-patient clinics have been running for a number of years. A diagnosis is made, and advice is given to parents, guardians or the patients themselves, to enable them to fit better into society and avoid the necessity for in-patient treatment in hospital. The Medical Officer of Health is advised as to the clinician's findings so that he may provide the community service for these patients.

The Report of the Royal Commission on the law relating to mental illness and mental deficiency divides the defective population into those who are severely sub-normal, and those who are psychopathics.

The latter phrase is a somewhat unfortunate one. It has been applied to Manuel, the multiple murderer of Scotland, and may equally well be applied to the gentleman who recently absconded from Broadmoor, to the distress of the surrounding population. Although the Royal Commission made a suggestion that the I.Q. of the severely sub-normal should be below 60 on the Terman Merrill Scale, not all psychiatrists are willing to accept this as an arbitrary figure. It is therefore to be anticipated that Parliament will have something to say concerning both definitions.

The Severely Sub-Normal

The severely sub-normal group are those who are incapable of supporting an independent existence without the aid of parents, guardians, or official help, and who may be placed without formality in Mental Deficiency Hospitals subject to the acceptance of the Clinical Director of the Hospital.

They may be placed at the instance of friends or parents, or in the case of children in care by the Children's Officer and other persons concerned. The object of this placement will be for care and training, and now no certificates, no legal formalities will be necessary with these people.

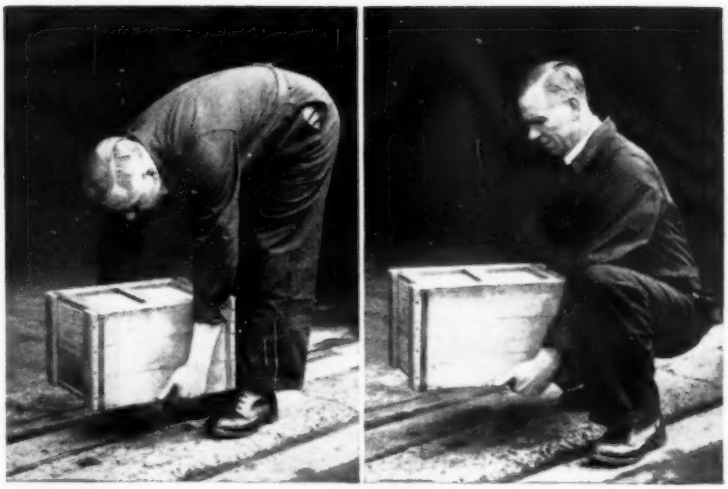
The position can therefore be summarised as follows. If the patient is over 16 and can express its own opinion, he should be asked if he wishes to stay in hospital. If he does not wish to leave he can remain in hospital even though his parents request that he should not. If, however, the patient is incapable of expressing his opinion and the relative asking for his discharge is his parent, guardian, or nearest relative, he should be discharged from hospital. The other provisions remain where relatives, other than the nearest relative, wish to be responsible for the care of the individual.

Lifting and Carrying

Recently **District Nursing** published a series of photographic features on the application of the new principles of posture and lifting to public health nursing.

H.M. Stationery Office has now issued a booklet, Lifting and Carrying (price 1*s.* 0*d.*), explaining with the aid of photographs the right and wrong way of dealing with loads for factory workers. The booklet points out that a better understanding of the principles of lifting, which depends more on skilful use of muscles than on brute force, could enable many of the 50,000 accidents a year caused in the lifting and handling of goods, to be avoided.

The advice in the booklet, of course, applies not only to industrial work, but to the every-day life of every man, woman and child.



WRONG **RIGHT**

The effort needed to lift a load by using leg and thigh muscles is much less than that needed when using the back and abdominal ones.

On the other hand psychopathic patients offer a much more serious problem. In many cases the usage of compulsory powers is essential if society is to be protected. There are certain patients whose behaviour is such that their detention in hospital may well be necessary not only in their own interests but in the interests of others. The Royal Commission recommends that compulsory admission to hospital of any psychopath under the age of 21 should be permitted if it is necessary for the patient's own welfare, but that such patients should not be liable to compulsory detention or control beyond the age of 25 years unless their admission followed a Court proceedings. Similarly, the patients will be given the protection of a review tribunal which will be set up in each region, and to which appeals may be addressed should the patient or his relatives feel that they are detained without good cause and reason.

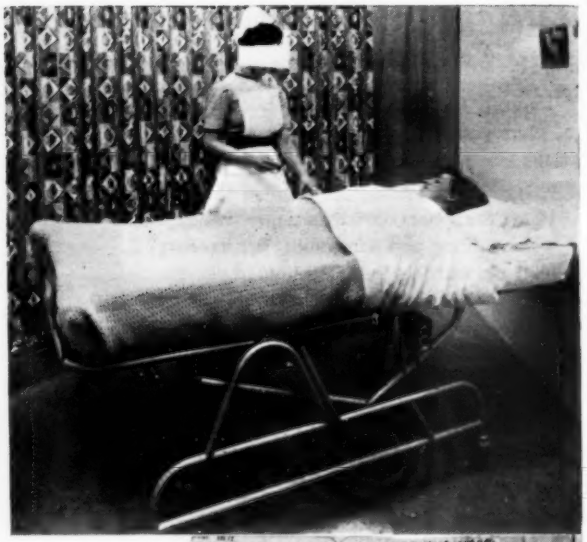
The duties of local authorities are very much more clearly defined by the Royal Commission. They will be empowered to set up hostels for the reception of mentally defective patients for residence within the community, and these hostels will be separate from such hospitals as are used for therapeutic training and resocialisation of mental defectives within the hospital system. For example we have two hostels. From one, forty to fifty women go to daily work in Norwich. Another has fifty-three men of whom 50 per cent work in farm, horticulture, and other occupations near the hostel.

On the other hand all hospitals have a proportion of patients who have no living relatives, whose behaviour is reasonably good and who, although not able to earn a living in competition with outside society, could yet well be considered for placement in a reasonably happy environment. There is however a good deal of controversy concerning the care of the patients. Many psychiatrists, myself among them, feel that a continuation of psychiatric care for these patients is essential. They tend to return to our hostels even when they are discharged for short holidays, or to see their friends who have not yet achieved full social status. One feels it may be difficult to staff local authority hostels, but it would be sad if those who have lived in our modernised hospitals should revert to any conditions comparable to 'poor law' in the past.

I hope to see in the future an extension of out-patient clinic facilities. I would like an extension of all diagnostic facilities. My present ambition is to have a diagnositc unit for young children in our own hospital, where patients can stay for two or three months for a careful study by psychiatrists, psychologists and others. I believe this unit should have attached to it a paediatrician, biochemist, radiologist, neurologist, physiotherapist and certainly someone with considerable E.N.T. experience. I would like to see this unit either close to a paediatric hospital or possibly within the confines of the mental deficiency hospitals themselves. The old prejudice against mental deficiency hospitals is dead. We have a large waiting list.

I would like to see in the hospitals a much more dynamic approach to training; better schools, better training facilities; some method of teaching how to live to the feebleminded who have come from bad homes and who need help in learning how to purchase the necessities of life, how to fill in simple forms, etc. Given time and money these things will come. They will be essential if we are to implement the Royal Commission's report which gives us much less time for training the defective.

Overcoming Bed-Weariness



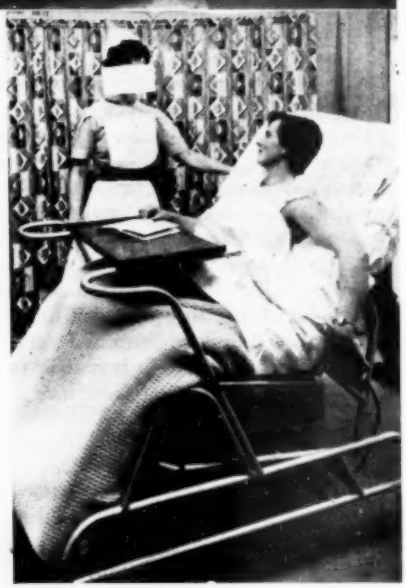
FEW people have escaped experiencing the discomforts of confinement to bed for a spell of days or weeks, and the longer the spell, the greater the discomforts. In acute illness, the patient is usually glad to lie flat but, at the first sign of convalescence, he wishes to sit up, and then the trouble begins; for beds are designed to lie in, not for sitting-up.

There are two main reasons for the discomfort that ensues. Propped up with pillows or back-rest the patient slips gradually down because his seat and legs are resting on a flat surface and there is nothing except friction to keep him up. This friction is exerted upon the skin covering the upper part of the buttocks and the sacrum, which was never intended by nature to cope with such treatment. If the process is prolonged the skin, as every nurse knows, will break down unless it is carefully tended.

When we sit in an easy chair, the seat is tilted to meet the slope of the back. Moreover, we bend our knees and put our feet on the floor. We may rest our feet on a stool for a short time, but the straight-knee position is not comfortable for long. Yet an unfortunate convalescent in bed has no alternative but to keep his feet up and his knees straight for hours on end. To overcome this bed-weariness an engineer and a medical practitioner have designed an adjustable bed. Known as the Egerton Adjustable Bed, this enables even the most enfeebled patient to change his position as often as he wishes without anyone's help.

The bed is fitted with a small electric motor operated by two push-buttons. Pressing one button causes the bed to change slowly from the flat to the sitting-up position. When the button is released, the movement stops. Pressing the other button reverses the process.

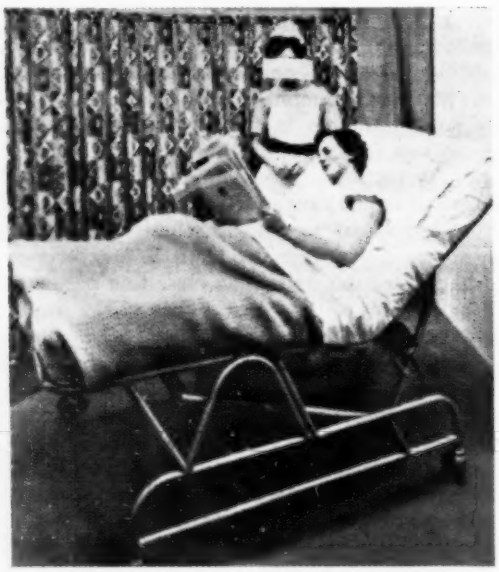
If the patient prefers, the foot-section can be fixed in the flat or slightly sloped position, leaving the back and seat sections free to move under the patient's control.



A press of a button by patient or nurse can bring the bed into a sitting position

In the case of an unconscious or helpless patient, the change of position can of course be effected by the nurse using the push-buttons instead of lifting the patient.

As can be seen in the illustrations, when the back is tilted up, the seat is tilted down to meet it. All tendency to slip down is eliminated.



If desired, the foot of the bed can be fixed in a flat or sloping position, with the back and seat sections free to move under the patient's control.

The bed is mounted on a chassis. The wheel base is only 4 feet and is supported on large wheel castors with locking brakes. There is no foot-rail across the chassis so that, from the sitting-up position, the convalescent patient can step on to the floor and walk away.

Strong hand-rests are provided to help him stand up. They also serve as a rest for the bed table and as lateral supports to guard the confused patient from falling out of bed when sitting up.

Special types of switch control can be devised for any kind of paralysis. A special fitting has been designed to allow of head-down tilting, and other medical and surgical needs have been anticipated.

The basic price of this model is about £70 and certain discounts are allowable in special cases. A second model operated through hydraulic hand-pump is priced about £63. More details can be obtained from Egerton Engineering, 1 Walters Yard, High Street, Bromley, Kent (Ravensbourne 8632).

The author who is Director of Education, West Sussex, is a pioneer in the move to abolish the Eleven-plus examination.

Selection for Secondary Schools

by C. W. READ, Ph.D., B.Sc.

BEFORE the 1944 Education Act introduced the principle of " secondary education for all ", there was a sharp distinction between the elementary school, where education stopped at 14, and the secondary school, offering a privileged education to the small minority who entered, usually at 11, by payment of fees or by means of a scholarship won in a stiff competitive examination. In 1926, for example, there were 76 free places in the secondary schools of West Sussex, and some 3,000 children between 10 and 12 took the examination papers for these places.

Since the war, however, a new system of schools has been developed—the old term " elementary " has disappeared from the scene, and children now attend primary schools until the age of 11, when they move on to a secondary school—usually grammar or modern schools, although in some areas there are also secondary technical and comprehensive schools. In West Sussex there are now well over 1,000 places each year in secondary grammar schools, where tuition fees are no longer payable, and over 4,000 in secondary modern schools.

To allocate 6,000 children to the most suitable type of school is no mean task, and the West Sussex Authority has given much careful thought to its selection system. It has appointed an Advisory Committee, composed of teachers from primary and secondary schools and members of the Education Committee, and, as a result of the Advisory Committee's discussions, the selection system has steadily evolved from decisions based solely on written examination results, into an attempt to find out the real educational needs of each child, viewed as an individual.

Several factors are considered in reaching a final decision:—

i the primary school record of the child's work and progress, especially in the final two years;

ii the primary school Head's recommendation on the child's ability and aptitude;

iii the scores obtained in a series of written tests, which are taken at intervals under ordinary classroom arrangements—the dates are not known in advance, except to the Head;

iv the parents' choice of school, provided that the school chosen is educationally suitable to the child's ability and aptitude and has enough room to take the child;

v in cases of doubt, a review of all the facts available, and, in some cases, an interview of the child by a panel which includes the Head of a grammar school and the Head of a modern school.

It is felt that this method can take into account factors that would be overlooked in the more impersonal system of written examinations, and that it helps to remove some of the anxiety which has attached itself, with the help of constant publicity, to the so-called " 11-plus examination ". Even so, children cannot be sub-divided neatly and irrevocably into separate educational compartments at the age of 11, as their rate of development and growth of interests will vary widely and affect their progress.

To meet this problem, the Authority has two lines of policy—first, a system of transfer between grammar and modern schools at any age, when it appears to be in the best interests of the child, and secondly, the development of curricula in grammar and modern schools sufficiently wide to allow an overlap in the education that they provide.

Traditions are not changed by the mere passing of an Act of Parliament, nor are all parents easily persuaded that *any* system of selection at 11 is fair and just. It has been the endeavour of this Authority to develop its method of selection and its provisions for secondary education so as to offer every child the opportunity of developing to the limit of its capacity, so that he or she may reach full stature as an individual and make the maximum possible contribution to the life of the community.

Nobody wants to 'go bush' the Australians said.
The bush spells heat, dust, and flies!

Nursing in the Australian Bush

by M. E. YOUNGS, S.R.N., S.C.M., Q.N. and H.V. certs.

IT was with mixed feelings that I packed up my belongings, resigned my post and went off to Australia for a year's working holiday. I had met some Australians, from Adelaide, a year before over here on a visit and their offer of hospitality, enthusiasm for their country and my own long cherished wish to visit Australia finally decided me to make the trip. I sailed on April 7th 1957, on the 'Orsova' (Orient Line) 29,000 tons and there was a full complement of passengers; for a complete change and a new look on life I recommend a long sea voyage.

We went out via the Cape of Good Hope as the Suez was not open at that time, our first call being Las Palmas (Grand Canary). Here we spent a day and for the first time I saw bananas growing in profusion. On board during the evening we were entertained by Spanish dancers, most attractive in their national costumes. We sailed from Las Palmas at 6 p.m. and I must mention that three passengers literally 'missed the boat' and had to be brought out in a launch and hauled up on deck. It must have been a terrifying experience for them; I understand they had to appear before the Captain the next morning!

All was now set for a nine days voyage with nothing to see but the sea; our next port of call being Cape Town which we reached on May 7th. We docked about 6 a.m. and the sun coming up over Table Mountain is something unforgettable. We were off the boat by 9 a.m. and I took a trip up Table Mountain during the morning and in the afternoon visited Kirtenbosch Botanical Gardens, some seven miles out of Cape Town, which are well worth a visit.

We sailed again about 6 p.m. for our last long hop before reaching Freemantle on May 17th. We were able to spend a day in Perth, my first glimpse of Australia; I must say I liked what I saw. I landed at Adelaide on May 20th and was met by my friends.

I had decided to work during the first six months and sightsee the remainder of my stay, so after a look round Adelaide, a well laid out modern city with sandy beaches in the south and the Mount Lofty Ranges in the north, I went to see the Superintendent of the District and Bush Nursing Society of South Australia, Miss Florence Nield.

The D.B.N.S. is a voluntary organisation with a government grant. There are branches, like our Nursing Associations, in every suburb of Adelaide, each branch contributing to Headquarters. The upkeep of the Sister's car is the responsibility of the Branch for which she works. I was invited to go out with one of the Sisters on her round. The work follows much the same pattern as the work of the District Sister at home. There is no special training and I think the Sisters work at a disadvantage because of this, although their equipment is good.

The patients pay for each visit, 5s. being the average. There is no charge for old age pensioners, but as there is no contributory scheme and pensions are granted only after a means test, the number of pensioners is less than in Britain.

I was surprised to find that the Sisters never work on Sunday, and it is an exception rather than rule if one has to visit on Saturday mornings. I enquired what happened to sick patients who might need nursing care, and was told this would be arranged through the Red Cross who would provide a private nurse, for which the patient would pay. There is a five day, 40-hour week throughout Australia, and in hospital overtime is paid in excess of 40 hours.

Two Hundred Miles to Doctor

I was impressed by Sister's uniform, although it was early winter (first week in June). She did her round in a smart white overall and no hat, the temperature being about 70° ! Aprons are not worn. There is no staff shortage for these urban districts. The greatest problem is to staff the Bush Nursing centres and I was asked if I would consider going up to a small Bush Hospital (three beds) at Marree which is 400 miles north of Adelaide.

It was a township of some 200 inhabitants, 100 of which were white the remainder being Aborigines (full bloods and half castes) and Afghans. The Afghans were descendants of the camel train drivers, who transported freight north of Marree before the railway was extended to Alice Springs in the early years of this century. I agreed to go up north to this outback township for three months. The need was great as the hospital had been closed for three months, Miss Nield being unable to supply a Nursing Sister. I wondered what I was going to be up against as my only medical contact was by radio to the Flying Doctor Base 200 miles south at Port Augusta.

My friends were flabbergasted when I told them I had agreed to go. They were born Australians and had never had any urge to 'go bush'. In their opinion the bush spelt heat, dust and flies!

I arrived at the best time of year at Marree. Cold in the morning and at night, but around 70 degrees by day.

In the summer it is often well over the century. January, February and March are the hottest months.

I travelled up to Marree on the bi-weekly train known as 'The Ghan' because the first passenger to buy a ticket on the very first train to travel from Adelaide to Marree is said to have been an Afghan. It was a very leisurely journey, the 400 miles taking 22 hours. This included a five hour stop about halfway, because of a break in railway gauge entailing a considerable amount of transhipping, freight as well as passengers. Travelling on a narrow gauge track is anything but comfortable.

I was met at Marree where I arrived at 6.30 a.m. on June 4th, by the policeman, Mr. Jim Sykes, who was also honorary secretary of the hospital. In fact I discovered there were very few official posts that Mr. Sykes did not fill: he was even the health officer. He took me to the hotel, a fair sized stone building—the only stone building in the town—where Mrs. John, the hotelier's wife, gave me breakfast and invited me to come back to lunch. This she said would give me time to get provisions.

My first impression, apart from the warm hearted welcome, was of sand and space! The 'road' running through the town, the only one from Adelaide to Alice Springs, was a sandy track, impassable when it rained, and likely to cause bogging in the sand in drought.

The railroad went straight through the town. On one side the hotel, store, hospital, police house, post office, school and hall were situated and on the other the Aborigine camp, a few houses inhabited by the Afghan families and some eight or nine houses occupied by railway employees. This was the small community in which I lived and worked for three months.

The hospital was double fronted, with a wide verandah all round. Two rooms on one side for patients and my office-cum-sitting-room and bedroom on the other. The kitchen ran the width of the building at the back. There was also a bathroom, laundry, surgery and a small room for Aborigine patients. These had been built on after the original building had been completed.

The radio transceiver was in the sitting-room. I was somewhat puzzled by all the knobs, dials, etc., but Jim Sykes showed me how to make a call and I was soon at home with what was to be my standby in emergency.

Marree was linked with the R.F.D. base at Port Augusta. This was a new base and had no flying doctor yet appointed, so calls were answered by one of the general practitioners at Port Augusta. He was not able to come out to emergencies but a plane would be sent to take the patient to Port Augusta Hospital. The plane came up to transport patients five times during my stay. The cases were: a three-months miscarriage, a severe case of allergy, a badly burnt rabbit trapper, a severe eye injury and an old man of 86 with acute retention. In other cases which I had to seek medical help, instructions were given over the radio after I had given the doctor a full account of the patient's symptoms.

The children were the most worrying. I was apt to wonder whether the tummy ache might flare up into an acute appendix, and the chesty cold into pneumonia. I always admitted a child for observation, especially the Aborigine children who become chesty very quickly. The doctor invariably orders sulphadiazine and penicillin in cases where the temperature is raised.

I treated a great number of boils and a peculiar skin

Continued on p. 146

The author with some of her young Aborigine patients at Marree where she worked for three months.

Recently we published the prize-winning essay on this subject in the B.M.A. competition. Here the runner-up brings a different but equally constructive approach.

The Public Health Nurse's Contribution to Family Life

by MARY K. CHISHOLM, S.R.N.

FAMILY life is in the end, the foundation stone, on which is built the greatness of our country.

Politicians, orators, statesmen, have their day, and are gone, but the family in all its frailties endures.

To the public health nurse is given the very great privilege of serving in the homes of the people. Her position is uniquely different from that of the hospital nurse, who has the backing of a great institution behind her. The hospital nurse is vested with authority and a certain degree of mystery as she goes about the wards.

The patients seen against the perspective of unfamiliar surroundings, perhaps a little afraid, are different people from their normal everyday selves.

In the homes, however, the nurse is the visitor, and must show tact, understanding, and above all, kindliness, if she is to be accepted. It is not her right to enter, and this fact cannot be forgotten. If therefore, she is to make any worthwhile contribution to family life, she must be a familiar figure, respected and well liked. Once such a position in the community is gained, the nurse has taken the first successful step in her work. And it is not always easy to accomplish this. There is prejudice (often from professional colleagues) to be broken down, confidence to be gained, and sometimes loneliness to be overcome. If however the public health nurse makes even a small contribution to family life, then the effort is well worth while.

Human Variety

The first thing that catches the interest of the nurse on the district, is the variety of human problems which she encounters even in the course of one day.

There is the young mother who has married early in her teens, and though still very young, is burdened by the cares of a home and three children. She is happily married but somewhere at the back of her mind, is a shadowy image of the youth she had never had. Frustrated, at times depressed, she is like a bird with untried wings.

The nurse can help this mother with advice on problems concerning the children, but that is only a very small part of her job. The real crux of the situation is the understanding which the nurse can give to this mother. She can listen sympathetically to what is said, and can give practical advice. She can by her very manner comfort this young mother so that she feels that her troubles are shared. Perhaps interest in some young mothers' circle can be aroused, if loneliness is the problem.

Praise of her care of the children may also uplift the mother, and a word of encouragement cheer her to further effort.

In mothercraft sessions much can be put over to the ante natal mothers, which would fall on barren ground once baby is born, and life becomes too full of work and bustle. This is the time to explain to the young mother the wonderful relationship which will be built up if she feeds her child. Anyone can give her baby a bottle, but only she can give it its natural food. The mother who is contented and happy before and after the birth of her baby will bring blessing to her home, and the public health nurse can do much to ensure that the mother is well prepared.

Help with budgeting is part of the duties of the public health nurse. How many homes are harassed through unwise spending. Today there is a ceaseless striving towards a mirage, that bright picture of luxury. Gradually the clear image of contentment with what one has, fades, and one is left grasping the shadow instead of the substance.

The health visitor can play a part here. In mothercraft talks for instance, she can point out that by buying a single bed size blanket which can be folded in two, instead of a cot blanket, money can be saved. She can show patterns and give hints on sewing, so that mothers may again save money. It can be emphasised that spare money should be spent on buying the best quality napkins, which will last baby far longer and in the long run prove an economy.

By giving advice on food she can help the mother again to economise by suggesting nourishing food, which is not necessarily the dearest.

Where a member of the family is on a special diet e.g. diabetic, obesity, etc., much trouble can be caused. Mother is often worried at having to cook special food. Sometimes it is the monotony of the diet and the sameness of the preparation of the food, which discourages her. Expense may be a factor, or often lack of knowledge. Sympathetic advice from the nurse, alternative suggestions of food, methods of economy in buying, all these

are within the scope of the nurse, and may help the mother.

It may only be the difficult appetite of a child, which is causing worry. Many children ' play up ' over food, and harassed mothers coax and plead, while their nerves are reduced to threads! Helpful advice on making food attractive, and giving small helpings, etc., can be very valuable.

Many mothers, particularly in the post natal period, suffer from a degree of anaemia, and dietetic advice on the value of foods such as liver, milk, eggs, and so on, may prevent much ill health, tiredness, and lack of interest. Indeed food plays such an important part in everyday life, that even the smallest help from the nurse may be a worthwhile contribution.

Preaching Prevention

By helping to prevent home accidents the public health nurse can do much for the family. How often is a shadow cast by a preventable burning accident, or by accidental poisoning. Many mothers acquire a fire-guard, but how many say after an accident has happened, " I only took the guard away for a second ". Or how often does a mother say, " I only turned my back for a moment "?

This is a rich field of preventive work for the nurse.

Many a mother, also, rues the day when, through ignorance or thoughtlessness, she allowed baby to feed himself in his pram, the end result being death of the infant, due to inhalation of vomit. Prevention must be preached all the time in order to lessen the increasing number of accidents in the home, with the ensuing heartbreak for parents.

A mother once met the public health nurse, in the street, and said, " I've had such a night of toothache, nurse, I'm just not fit for anything."

On being asked if she was on her way to the dentist, the woman said hastily, "Oh, it isn't that bad."

Obviously the whole family were going to suffer. Similarly if wee Tommie has an acute attack of toothache, he also is going to make his presence felt in the family circle!

Talks on the care of the teeth can be given to groups of ante natal mothers at clinics, and advice given, during home visits. Most mothers are surprised to learn that the seeds of their children's teeth are laid down in the ante natal period.

Nursery school children learn tooth drill at an early age, but there is nothing to prevent the child at home practising tooth hygiene as well. The school nurse can carry on this advice and can point out the importance of regular tooth inspection. Thus a little may be done, with the aid also of dietetic advice, to prevent the scourge of toothache.

The idea of prevention comes into every aspect of the public health nurse's work. The district nurse who syringes granny's ear can discuss the prevention of ear trouble, and may even, if she is lucky, be able to discourage her from using a hair pin for removing wax, or from inserting drops of almond oil from a rather dubious looking bottle!

There is in many families a so-called problem child. A mother once said of her daughter, " She's so sly, I can do nothing with her."

The said child sat in a corner, while the mother catalogued her failings, a sullen look on her face. She was also an enuretic, to add to her crimes, and of course her little brother of eighteen months was such a clean child.

Here again is a problem which requires much patience and understanding. Many visits may be required, in order to build up a relationship with the family. Once they are allies, the nurse can often do much to inflence the family by explanation, and by calling on any agencies who may be able to help, and with whom she works in co-operation.

Sometimes the nurse notices, on visiting a home, the child who is ' different '. Perhaps he may have some disability, or is perhaps not so strong as his more fortunate brothers and sisters. He may be intensely miserable in his strivings to be one of the crowd. George Crabbe once wrote:

" There you may see the youth of slender frame
Contend with weakness, weariness, and shame,
Yet urged along, and proudly loth to yield,
He strives to join his fellows of the field,
Till long contending nature drops at last,
Declining health rejects his poor repast."

There was a boy who had a heart condition which prevented him from doing normal work. He was eventually sent to a rehabilitation centre, but after a few days stopped going. His mother told the nurse who was visiting some of the younger children that day, how miserable the boy was. His friends had money to spend, they could visit the cinema, go dancing, and play football.

The nurse contacted the welfare worker at the centre, who made arrangements for the boy to come back, and who also arranged for the boy to be put in touch with a social club where he would meet similarly handicapped boys.

His mother allowed him to invite his friends to the home, and the father was encouraged to take more interest in the lad. Also a degree of priority was granted by the housing department, when the case was brought to their notice by the nurse's report, to allow the family to obtain a ground floor house. This is only one instance of how the physically handicapped may be helped.

But what of that vast problem, the mentally handicapped? Many times will the public health nurse have to visit the home where there is a mentally handicapped child. Though the problem is essentially the same, the approach may be quite different. If this tragedy occurs in a home of the professional classes, the agony of mind endured by the parents may be no less than that of other parents, but may show different expression. On the whole there is a more free and easy acceptance of such

a child in the poorer districts, perhaps because those people are accustomed to life's hardships, and having always had to battle for existence accept the misfits more readily. Also they do not have the same feeling of almost personal shame. In other homes the child is sometimes too fiercely protected.

The nurse must feel her way, and advise as chances arise. It is unwise ever to allude to the fact that the child is backward as a rule, but as the fact slowly dawns on the parents, be ready to offer practical advice. It may only be advice on the easiest way of feeding the child, or advice on helping the child to become more independent.

Once a very happy meeting between two mothers of handicapped children was arranged by the nurse. The mothers were able to meet over social cups of tea, and could discuss their mutual problems. A friendship also sprang up between the children.

Sometimes, talking over the problem of the mentally handicapped child with the headmistress of a nursery school, may be beneficial. Many backward children improve enormously in the company of other children.

Mental stability is certainly needed today to combat the rush and bustle of life. The public health nurse does well to cultivate a well balanced outlook, and serene faith which can be transmitted to the people amongst whom she works. To be a good anti-depressive is rewarding in many ways!

To stand alone for a while and to spare time to examine problems, often gives a new slant and a new hope. A sense of humour is a priceless gift.

The public health nurse works with all, from the very young to the aged. The latter often have a great bearing on family life. If everyone could be persuaded to prepare for old age, so that it was a gradual and happy passing from the swift pace of youth to the slower tempo of added years, many problems would be solved.

Preparing for Old Age

How many men and women spend a lifetime working, and enjoying pleasures, which cannot last into old age? The elderly man who is now unable to attend a football match, or to go round the corner for a drink with his friends. The old woman who has kept house, and filled her life with the cares of her family, finds the family scattered, and her own life empty. Often it is too late to pick up the threads and weave a new life pattern.

The public health nurse is often called upon to give talks to varied groups of people. This theme of preparation for old age, and the wise use of leisure is important. To develop a hobby in middle life, which can be carried on in later years, to cultivate new interests, to add to their storehouse of knowledge, will give added zest to old age. One old lady of nearly eighty used to attend a literature class regularly, and her own reminiscences made fascinating hearing. An old man still took a keen delight in adding to his not inconsiderable stamp collection.

Thus indirectly may a contribution be made to family life, because the problem of the aged is often great. Visiting the old, is also a rewarding part of the public health nurses work, and often practical help can be given or acquired. Even simple things such as putting the old person in touch with a chiropodist, may sweeten the family circle!

One old soul who had been in hospital and who came home to a house, which had been cleaned up for her by enthusiastic voluntary helpers, had one grievance. They had thrown out her jumpers. Possibly the said jumpers were old rags, but nevertheless they had been her pride. The nurse who was asked by the hospital to follow up this old lady, managed to obtain a fresh supply of (to the old lady) vastly inferior jumpers from the almoner. After a few visits the patient became very friendly, and having lost her first suspicions, confided in the nurse that she had a sister in Canada. At the old lady's request, the nurse wrote to this sister who was even older, and once more a family link which had been broken was established.

Education for Leisure

Where youth are concerned, talks on the use of leisure, on the futility of constant spoon-fed entertainment, on the value of service to the community, and of course healthy living, can have an effect on family life. The age of adolescence brings its problems to the family circle, and it seems a terrible reflection on life today, that so few young people use their homes, for other than eating and sleeping in. Any contribution which the nurse can make, either by advice to parents, or by her work in schools, etc., is of some value to the family as a whole.

Lack of sleep inevitably causes irritation as all who have ever indulged in a late night know. If therefore the public health nurse is able to help the harassed mother whose infant or toddler will not sleep, she is aiding peaceful family relations!

Sometimes small practical points help: for instance pointing out that too quick feeding predisposes to wind and indigestion in the infant, and therefore wakefulness. By advising the mother on a simple measure, such as giving boiled water before feeds, or by using a teat with a slightly smaller hole, if the baby is bottle fed, good results may be achieved. In the case of the toddler, it often happens that the child has a hilarious romp with father just before going to bed. Listening to father reading a story before bedtime may mean a peaceful night for mother, and a serene family circle the day after.

In the case of adolescents also, this need for adequate sleep in a well ventilated room should be emphasised.

There is always the difficult family on the district: the one who has successfully resisted all attempts to improve their lot. The public health nurse comes soon to realise, of course, after her first zealous zeal is over, that often the family, though living in conditions far from desirable, are happy. To change them completely might make them acutely miserable. It is given to no

one the right to force their beliefs and ideas on to others. Friendly advice is another thing however. Perhaps the most important thing when dealing with so-called problem families, is not to look around for something to blame but for something to praise. There is always sure to be something to comment on, whether it be a change of wallpaper or of cushion covers. If the mother realises that the nurse is not there to criticise her but to help her, a great deal has been achieved.

In this type of family the nurse may make a contribution simply by her neat, tidy, appearance; by her poise, and efficiency. Even the most feckless mother has an innate pride in herself if one only digs deeply enough.

Once a nurse on the district gave a mother a coat, which she herself no longer wanted. It had been quite a fashionable coat and the mother appeared pleased. At the next session of the child welfare clinic, the mother appeared for the first time in months, wearing the coat. She had no stockings on but she had washed her legs. Her straggly hair had been cut short, and was neatly brushed back. Altogether she was a very different person from the rather sluttish woman of a week ago. Her baby also had been bathed, and was cleanly clothed. Mother swept into the clinic and took her place amongst the other mothers as if she was a queen. From simple things great results are often achieved!

Where the public health nurse acts as a liaison officer between district and hospital, she can help the hospital in many ways.

One mother was told at hospital that she could have her baby operated on for a hernia as an outpatient, and have him back the same day. She did not like to mention to the surgeon that she had six other children at home, living under poor housing conditions. However she did tell the nurse on the district that she did not see how she was going to manage. The liaison nurse reported back to the hospital, with the result that the child was admitted, and stayed until his stitches had been removed.

It is also a comfort to many mothers, to know that the nurse with whom they are very familiar has seen the children, and she can reassure them even if it is simply by passing on the report they have already received. She can also be of service to the hospital almoner by her knowledge of the family background.

The general practitioner with his increasing burden may find many ways in which the public health nurse can be of help to him, and to the families whom he serves.

Where there are feeding problems, for instance, the nurse can go in and observe the feeding and report back to the doctor.

Once a nurse, paying a purely routine visit to a home, found a child who was quite seriously ill, but whose mentally, rather backward, mother had not realised the fact. The family doctor was visited, and the child was admitted to hospital.

Meetings with general practitioners on the district, where problems can be discussed and where the doctor can advise the nurse on the lines he wishes followed, are of value to the families concerned. Where there is good liaison between general practitioners and the public health nurses, there is bound to be benefit to all the families concerned.

The husband of an ante natal mother on the district died suddenly. His wife was numbed by the shock, and was visited frequently during her pregnancy by the public health nurse. This mother was at first distraught, and asked the nurse on several occasions how she could arrange to have the baby adopted. Gradually, however, she became calmer and discussed many problems and fears for the future. She was, she admitted, glad to have someone who was not one of the family, but whom she knew was interested in her troubles, to talk things over with. Eventually the baby was born and she appeared at the clinic with her. When asked if she was still thinking of adoption, she replied, "Of course not."

There are many other ways in which the public health nurse can contribute to family life. For instance she can often spot the first signs of mental breakdown. She can notice when the mothers whom she visits are over-tired, and worried with family cares, and can arrange with the almoner for holidays for them, if they are interested in going away for a short break. She can help to promote pride in achievement in the handicapped mother, and so on. Then from time to time she can refresh herself by pausing to consider the beauty of life, in the most unexpected places. Thus she comes to realise, as never before, the value of a united home to the community and to the world at large.

The public health nurse is given a broader outlook, and is thus able to bring her increased experience over the years to the homes she visits. Her district becomes to her a canvas on which is painted the rich colours of human living.

As Shelley so aptly puts it: "*The mist of familiarity obscures from us the wonder of our being.*"

CHRISTMAS ON THE DISTRICT

We invite **YOU** to contribute to the extra special enlarged Christmas number that we are now planning.

Write and tell us in not more than 250 words your favourite story about 'Christmas on the District'. It may be a personal experience, or a Christmassy incident involving one of your patients. A humorous anecdote, perhaps; a ghost story; or a simple human story of joy, pathos, goodwill.

Post your entry to: The Editor, District Nursing, 57 Lower Belgrave Street, London, S.W.1., to arrive by not later than 31st October, 1958.

Prizes of **THREE GUINEAS, TWO GUINEAS,** and **ONE GUINEA** will be awarded for the best three entries received, and we shall pay **HALF A GUINEA** for every other story published. The Editor's decision is final.

NURSING BOOKSHELF

Duke's Bacteria in relation to Nursing. Third edition revised by **Stanley Marshall, M.D., B.S. (Lond), M.R.C.S.** 216 pages. Eighteen illustrations, twelve in colour. (H. K. Lewis and Co. Ltd. Price 21*s*.).

How much bacteriology ought a nurse to be taught and what should be the extent of the Sister Tutor's training in the subject? These questions arise when looking through this third edition of Duke's useful book which has been carefully revised by Dr. Stanley Marshall.

The answers to the questions are not easily given but most would agree that the large text-books are too big and too detailed for both student-nurses and their teachers. Does this little manual contain enough? We should certainly say that it does.

On looking into it one finds a lot of factual information, not only about the nature and varieties of bacteria but also about the ways in which they attack the body and how the body reacts to their attack—in other words the production of immunity. An important section deals with the methods of obtaining specimens for the bacteriologist to test. The commonly used antiseptics are described and the great therapeutic advance consequent on the discovery first of the sulphonamides and then of penicillin and other antibiotics, is graphically depicted.

We would like to see a small addition to the therapeutics of penicillin—a cautionary word to the effect that it is dangerous to inject penicillin into the spinal theca except in small doses—i.e. about ten thousand units. We have known a very serious result to follow the injection of a large dose by lumbar puncture where the doctor ordered it by mistake and the nurse who prepared it did not know of the danger of large doses injected intra-thecally.

The final chapter on practical bacteriology may surprise some persons, but the author himself explains why it is there. 'The object in view is not to train the Sister Tutor to become a laboratory assistant but to make her into a more efficient and intelligent Sister Tutor, and also of course to help her to pass her examinations'. Certainly looking through the practical work would make one think it was intended for medical students. Perhaps it may induce some sister tutors to study medicine. Who knows?

Zachary Cope

Handicrafts in hot climates (N.A.P.T. 2s. 6d.).

How can an African patient separated from his tribe settle down to long treatment in a mission hospital many miles from his kraal? What can a Red Cross welfare worker visiting a sick woman in a Malayan jungle do to keep up morale?

These are some of the practical questions answered by the N.A.P.T.'s new booklet, "Handicrafts in Hot Climates", prepared by a committee of experts—doctors, nurses and occupational therapists with experience of working overseas. This handbook is intended as much for the pioneer-enthusiast and voluntary worker as the professionally trained officer. It suggests the application of some simple guiding principles in the organisation of many different activities and educational schemes.

Child Health & Paediatrics by R. McL. Todd (William Heinemann Medical Books Ltd., 21s.).

This small text book of 230 pages which sets out to cover the wide subject of Paediatrics and Child Health is a hand-book which would be most useful to social workers needing a little special knowledge; but as a text book for student health visitors and district nurses it is not, I feel, sufficiently comprehensive. The first part of the book deals with the promotion of health and the normal child and it is clearly and concisely written; I would mention

correspondence

Nursing Bags

I AM greatly interested in the proposal of introducing a new type of nursing bag for district work, but wonder if any thought has yet been given to the needs of the male district nurse who is required to carry his long white coat with him.

During training, I was supplied with a second bag for this purpose, which although fitting the requirements, was an extra burden to carry around.

I now use the metal-box type bag with cloth outer covering which has a small pocket at its side and this is totally inadequate for carrying my coat.

In view of this, I suggest that a much larger pocket or division might be adapted in the idea for the purpose of carrying the coat. If large enough it could still carry the towel and soap, etc.

I also would like to point out, that when using autocycles on the district, the nursing bag is carried on the carrier and does undergo a great shaking about and general heavy wear; and in consequence, the cloth outer covering becomes a piece of rag, tattered and torn within only a few months. A remedy for this would be a great improvement and a saving to the employing authority.

In conclusion, I think that careful thought must be given to its use and lasting power. While appreciating the need for something light for those who personally have to carry it around with them, such a bag would not last six months if used in conjunction with autocycles.

(Mr.) F. Bell, S.R.N., Q.N.
36 Tower Avenue, Lincoln.

The Manchester Home

IN the report (July, p.81) on the "Training and use of the S.E.A.N.", Miss Dolton states: "In Manchester recruitment was difficult and the Home is being used for Midwifery training."

This statement is quite inaccurate. The Home is not used for Midwifery training, and the Superintendent concerned says she did not, and indeed, could not, give this information to Miss Dolton.

Her explanation to her Home Committee is that no suitable candidates have come forward for training as S.E.A.N.

Edith Roberts,
Hon. Secretary
Manchester District Nursing Institution,
3 St. James's Square, Manchester, 2.

Miss Dolton asks us to apologise for the mis-statement which occurred whilst she was opening the discussion at the Non-Training Home Study Day without reference to her detailed notes. These did in fact make clear that the Home is not being used for midwifery training, although midwifery is practised from there. Editor.

Letters should be addressed to: The Editor, District Nursing, 57 Lower Belgrave Street, London, S.W.1.

The Integrated Course of Nurse Education

THE Integrated Course of Nurse Education has really begun. Eleven students were enrolled and began training at the Hammersmith Hospital Post-Graduate Medical School of London on 5th September, 1957. This great moment in the history of nursing took place with particular attention being paid only by those intimately concerned, either as students or teachers in the hospital, or from the health visitor training centre or the Queen's Institute.

Most readers of this journal probably know that the Integrated Course of Nurse Education is a four-year course which will cover the syllabuses of:

a The General Nursing Council for England and Wales (General Register)

b The Central Midwives Board (Part I course)

c The Royal Society of Health (Health visitor course)

d The Queen's Institute of District Nursing (District nurse course)

and has received the approval of each of these bodies, being finally sanctioned by the Ministry of Health on 28th February, 1957.

Prominence was given to this sanction in most of the London and provincial newspapers, and the *Nursing Mirror* and *Nursing Times* published special articles describing the scheme.

Most of the applicants for the first course came as a result of these announcements; since then the Association of Education Committees has recommended the courses to local education committees and most of the grammar schools in the country have been given details. Enquiries from the careers mistresses or from girls in the sixth form are now coming in regularly.

The average age of the students enrolled in September was more than 20 years of age. All had passed the General Certificate of Education in English language and at least four other subjects at ordinary level, and two subjects at advanced level. They were chosen for their enthusiasm and character as well as their educational background. Some joined the course straight from school; among the others were students who since leaving school had taken a university degree, completed teachers' training, studied law or undertaken some social work.

The curriculum of the Integrated Course of Nurse Education is designed to integrate the courses of the four organisations concerned, so that curative nursing is taught side by side with public health nursing.

The eleven students formed part of a preliminary training school of 50 students at Hammersmith hospital. A great deal of the timetable was arranged for all the students, but the 'integrated' students received special lectures in psychology and personal and communal health, some of which were given at the health visitor training centre at Battersea College of Technology. The Health Visitor Tutor from Battersea and the Queen's Institute's Education Officer visited the school and gave talks on the history of health visiting and district nursing, and took part in general discussion with the students.

The ordinary and the 'integrated' students mix together extremely well and the 'integrated' students are known as 'the first eleven'.

The students went away for two weeks holiday at the end of December and began ward work at the beginning of January. At the same time they began attending Battersea College one day a week and continued until the middle of April, for health visitor lectures and for practical health visiting experience under the careful guidance of L.C.C. health visitors. The home visiting gave the students a great insight into the social conditions of their patients.

All the students have now worked in at least two wards on day duty and have done their first spell of night duty. At present they are in the nursing school for five weeks taking the medical lectures.

Reports received from the ward sisters and from the superintendent health visitors on these students have been very favourable and show that they are taking an intelligent and enthusiastic interest in their practical training. They have taken the preliminary state examination, but the results have not been published at the time this article is written.

NURSING BOOKSHELF

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particularly Chapter VII "Growth and Development" with its simple charts and good illustrations.

The second part of the book goes on to deal with the diseases and disorders of childhood. Here we are given the symptoms diagnosis and treatment of the various diseases; but the golden opportunity of linking hospital treatment with after-care at home has been missed and I was left with a sense of disappointment on this account. As in the earlier part of the book the illustrations are well chosen; for example, the two typical illustrations on page 198 of a child with Pink Disease.

Quite a useful little book with limitations.

D.K.N.

Smallpox and Vaccination.

This is one of the Conquest Pamphlet Series, published by the Research Defence Society, 11 Chandos Street, Cavendish Square, London, W.1.

This booklet gives information about smallpox and vaccination in question and answer form, which would help nurses to answer queries raised by the mothers of young children and others.

Other pamphlets in this series are Anti-poliomyelitis Vaccination, B.C.G. Vaccination against Tuberculosis, The Research Defence Society, Some Reflections on Animal Experiments, and Diabetes—at a cost of 6*d.* each.

R.A.B.

District Nurse Carter by Lawrence Meynell (Chatto and Windus 8*s.* 6*d.* net)

Those who have read the Nurse Carter career novels *Young Nurse Carter* and *Nurse Carter Married* by the late Shirley Darbyshire will welcome a third book in the series written by her husband, Laurence Meynell, entitled *District Nurse Carter*.

This lively little story is particularly suitable for girls embarking on a nursing career, giving as it does an insight into the life and work of a Queen's district nurse.

Nurse Carter's experiences both grave and gay, first as a student district nurse and subsequently as a district nurse/midwife in a rural area, are bound to arouse interest in this branch of nursing with its human appeal and spirit of service.

L.J.G.

The Association of Queen's Nurses

Annual Dinner

THE Annual Dinner will be held at the Carlton Hotel, East Cliff, Bournemouth, Hampshire, on Saturday, 15th November, 1958 at 7.30 p.m. Evening or afternoon dress. Members may bring a friend.

Applications for tickets, accompanied by a remittance at the rate of £1 2*s.* 6*d.* per ticket, should be made to Miss B. I. Piper, Flat 4, 1 Archers Road, Southampton, by not later than 1st November, 1958.

BUCKS AND OXFORDSHIRE

A QUARTERLY meeting was held on July 29th 1958, at the Friarage, Aylesbury, with Miss D. T. N. Cole taking the chair.

The film "Going to Hospital with Mother", made by the Tavistock Clinic, at Amersham General Hospital, with commentary by James Robertson, was shown, and provoked much discussion.

A Bring and Buy Stall raised £4 for branch funds. The next meeting is to be held on October 21st at High Wycombe.

P. M. Earp

WEST RIDING OF YORKSHIRE

A RECEPTION and sherry party to meet Miss L. Joan Gray, General Superintendent, will be held at Kirby Leas, Halifax, on Wednesday, 24th September from 6 to 9 p.m. All members and friends are warmly invited.

Will those accepting the invitation please notify Miss Savage, Kirby Leas, Halifax, not later than September 20th.

MANCHESTER

AT a meeting in July at the Hulme and Moss Side District Nurses Home, the Manchester Branch of the Association of Queen's Nurses was reorganised. The attendance was 53, subscriptions were paid, and many new members joined. Honorary Officers and a Committee of six members were appointed. We shall hold meetings at least twice monthly and hope to be a very active branch. **Jenny Small**

We regret to record the sudden death, whilst on holiday of **Miss Margaret Susan Binney.** A Queen's Nurse/Midwife/Health Visitor since 1954 at Crowborough, she was much loved by her colleagues and her patients.

Miss J. Shepherd, whose account of the Royal Garden Party appeared in our August issue, asks us to state that her correct designation is "Assistant Supervisor of Midwives and District Nurses". The Superintendent for the East Riding of Yorkshire is, of course, Miss Bailey.

Miss E. M. Wearn, Superintendent of The Lady Rayleigh Training Home, Leytonstone, E.11, for the past fifteen years, is leaving at the end of September. Any past members of the staff who would like to contribute to the presentation that is being made to her, are asked to write to Miss J. M. Dingley, 485 Aldborough Road, Essex.

MORCOM MEDALLIST

WINNER of this year's Isobel Morcom medal given annually for outstanding service by a member of the district nursing service in Worcestershire, Miss A. H. Stokes has been district nurse/midwife/health visitor at Pershore since December, 1942.

The citation states that she has at all times maintained a high standard of work, giving valuable service to the community in which she serves. She is progressive in her outlook on the various types of district nursing work, co-operates well with her colleagues, and has always been interested in the general welfare of her patients.

Miss A. H. Stokes

Queen's Nurses

Personnel changes 1st to 31st July, 1958

APPOINTMENTS

Superintendents, etc.

Nagle, Margaret, Sheffield (Assistant Superintendent).
Thompson, Margery A., Bradford (Assistant Superintendent).

Nurses

Alexander, J. G., Worcestershire.
Baines, B. M., West Riding.
Barrow, J. R. (Mrs.), West Riding.
Baigent, P. (Mrs.), Kent.
Brady, M., Warwickshire.
Bray, H., Sheffield.
Chadwick, A., Gateshead.
Chalker, M. C., Herts.
Clarke, D. A., Shropshire.
Darley, I. M., Lancashire.
Davies, L. E. (Mrs.), Warwickshire.
Davis, F. M., Hertfordshire.
Donovan, H. M., Middx. Area 3.
Englefield, T., West Sussex.
Flenley, D. B., Lancashire.
Fletcher, B. H., Cornwall.
George, H. J., Oxfordshire.
Hare, A. J., East Sussex.
Henderson, G., Worcestershire.
Holden, R., Shropshire.
Hybart, C. M., Surrey.
Jessup, D., West Sussex.
King, E. M., Somerset.
Knowles, J., N. Ireland.
Krebs, E., Somerset.
Moss, J. E., Somerset.
Nash, C. R., Worcestershire.
Newby, M. E., Lancashire.
Osborne, J. B., West Sussex.
Overton, B. M., Middx. Area 2.
Powell, E. J., Warwickshire.
Roberts, S. E., Caernarvonshire.
Rogers, L. K., West Sussex.
Ronson, G. E., Lancashire.
Roundtree, M. F., Somerset.
Sodipo, I. Y., East London.
Tester, J. M., Oxfordshire.
Turner, E., Gateshead.
Walker, J., Leicestershire.
Wickens, E. E., Kent.
Williams, M. J., Cornwall.
Williams, M. R. (Mrs.), Oxfordshire.
Winter, D., Nottinghamshire.

RESIGNATIONS

Auchterlanie, J. E. (Mrs.), Portsmouth—Ill health.
Beall, S., Northants.—Retirement.
Cameron, D., Lancs.—Domestic reasons.
Carter, B. (Mrs.), Liverpool—Domestic reasons.
Caudle, W. P., West Riding—Retirement.
Coleridge, E., Gloucester—Retirement.
Copley, R., Rotherham—Domestic reasons.
Craig, K. G. (Mrs.), Herts.—Going abroad.
Cummings, M. A. J. (Mrs.), Worcester—End of contract.
Cunningham, J. (Mrs.), Reading—Domestic reasons.
Cunningham, A. (Mr.), Reading—Other work.
Dudson, E., Gloucester—Industrial nursing
Ellis, E. S. (Mrs.), Hunts.—Domestic reasons.
Elwood, B. P., Chester—Domestic reasons.
Evans, G. L. (Mrs.), Merioneth—Domestic reasons.
Flesher, J., Worcestershire—Going abroad.
Genner, M. C., Exeter—Work in Iraq.
Gammon, J., Southend on Sea—Ill health.
Green, G. B., Ilford—Hospital post.
Green, M., Huddersfield—Marriage.
Grubb, A. M., Gloucester—Hospital post.
Gwilliam, R. M., Shropshire—Post in Canada.
Hamilton, J. I., Kensington—Midwifery training.
Hawkes, M. E., Leicestershire—Domestic reasons.
Hayward, J. M., I.O.W.—Missionary training.
Hewitt, M., Bristol—Retirement.
Hills, B. M. (Mrs.), Devon—Retirement.
Hook, A. (Mrs.), E. Sussex—Ill health.

Jex, J. L. M., Essex—Marriage.
Knipe, J. M., Lancashire—Hospital post.
Lambert, G. (Mrs.), Rotherham—Domestic reasons.
Mackay, M., Kensington—Midwifery training.
MacWilliam, F., Liverpool—H.V. training.
Malcolm, P. M. (Mrs.), Halifax—Domestic reasons.
Marshall, M. C., Cambs.—Marriage.
Marshall, P. A. (Mrs.), Birmingham—Domestic reaasons.
Mason, H., Lancs.—Hospital post.
Meadwell, L. (Mr.), Lancs.—Other work.
McGillian, C., Lancs.—Retirement.
Menarry, F., Liverpool—Industrial nursing abroad.
Moseley, I. (Mrs.), Lancs.—Domestic reasons.
Palladino, E., Gloucester—H.V. course.
Park, M. E., Essex—Marriage.
Phillips, M. E. (Mrs.), Kent—Retirement.
Regan, A. M., N. London—Marriage.
Robinson, K. (Mrs.), Lancs.—Domestic reasons.
Rose, I., West Riding—Other work.
Sanders, E. E., Kensington—Midwifery training.
Sheerman, B. F., Exeter—Hospital post.
Smith, D. H. (Mrs.), Manchester—Domestic reasons.
Spencer, M. P. (Mrs.), Camberwell—Marriage.
Spinks, D. M., Kent—Retirement.
Stephenson, B. A., Oxford—H.V. course.
Tillotson, O., Birmingham—Retirement.
Tobin, J. E., Kensington—Hospital post.
Twist, M., Lancs.—Retirement.
Watson, E., Bristol—Marriage.

LEAVE OF ABSENCE
Barnes, V.—H.V. training.
Cooper, R. M.—H.V. training.
Cummings, M. I.—H.V. training.
Daniel, P. M.—H.V. training.
Haslam, M. J.—H.V. training.
Lumley, I. B.—H.V. training.
Malley, M.—H.V. training.
Masters, N. W.—H.V. training.
McGrath, M. F. (Mrs.)—H.V. training.
Turner, I. M.—H.V. training.
Walker, S. L.—H.V. training.
Walker, R.—H.V. training.
Waller, K.—Part II Midwifery.

SECONDMENT
Hedges, M.—B.R.C.S. in Cyprus.

Scottish Branch

APPOINTMENTS

Superintendents, etc.
McInnes, C. F., Glasgow (Bath Street) (Assistant Superintendent).

Nurses
Arthur, Rosemary, Bowling.
Bickers, C., Inverness.
Campbell, M. I., Stirlingshire—C.R.N.
Cowie, E., Insch.
Cumming, A. W. S., Elgin.
Hall, B., Polbeth.
Hood, A., West Calder.
Johnston, M. C., Addiewell.
Jones, B. M. M., Kilmarnock.
McCullum, M., Machrihanish.
Macdonald, I., Gravir.
Russell, J. C., Stranraer.
Sutherland, E., Inverness-shire—C.R.N.
Urquhart, I., Stirling Burgh.
Watt, R. G., West Calder.
Whatcott, I. R. M., Muirkirk.
Williams, A. C., North Knapdale.

REJOINERS
Atkinson, J. J., Glasgow (Govan).
Lea, Margaret, Aberdeenshire—C.R.N.
Lennie, C. C., Glasgow (Anniesland).

RESIGNATIONS
Bauchope, Elizabeth M., Taynuilt—Marriage.
Cameron, Mary C. M., Glasgow (Anniesland)—Home reasons.
Fitzpatrick, Christina, Glasgow (Dennistoun)—Health.
Foulis, Thora, Wardie—Other work.
Kellock, Margt. M. B., Glasgow (Govan)—Marriage.
Love, Margt. Simpson, Kirkcowan—Health.
McArthurm, Ina, Kenmore—Retired.
MacMillan, Henrietta, Caithness—Marriage.
Macmillan, De'Arne W. L., Edinburgh—Marriage.
McNaughton, Ellen Mc., Armadale—Other work.
Meakin, Hester Herbert, Insch—Retired.
Mitchell, Mary Ross, Oban—Home reasons.
Morrison, Chrissie Ann, Glasgow (Partick) Other work.
Ross, Margt. Pryde, Edinburgh—Other work.
Semple, C. H., St. Martins—Marriage.
Smith, Mary Bella, Edinburgh—Health.
Summerfield, Jessie C., Peebles—Retired.

DEATH
Macnaughton, Elizabeth—Late of East Carse.

Nursing in the Bush

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infection called ' Barcue Rot ', which was rather like impetigo except that the lesions did not appear on the face.

At one period as we had an outbreak of Asian 'flu and about 50 per cent of the population were affected including the policeman. Fortunately there were no complicated cases and most of them responded pretty well to aspirin and fluids. Some of the children ran very high temperatures. I was in daily contact with the doctor over these cases, in fact one day I think I ' went on ' at each session. Medical sessions were at 8 a.m., 11 a.m., 2.30 p.m. and 4.30 p.m.

There were of course ' gossip sessions ' when stations could chat to each other and indeed I often chatted with some of the wives whom I never saw. I had a regular chat with a Mission some fifty miles away. The wife of the Missioner was a trained nurse and it was a help to have some contact with her.

I ran a small welfare clinic each week. The babies were all immunised with ' Triple Antigen ' starting at six months. I had one ante-natal mother whom I delivered in the hospital before I left.

I also paid a weekly visit to the school. There was a ' hard core ' of infected heads when I arrived. Two half caste families were the culprits, but these responded well to regular supervision.

Before I left a dust storm blew up. I never imagined sand could cover everything in such a short space of time. It blew into every part of the hospital (which was typical of bush dwellings, and built of corrugated iron).

I swept the hospital passage from front door to kitchen at the back at least a dozen times during the day and still the sand blew underneath. Visibility was less than 100 yards and a hot north wind met one at the back door of the hospital. It was such a relief when the wind dropped and the sand settled once more.

The flies were pretty numerous especially out of doors. They covered one's back in no time and buzzed around one's face. I can see the advantage of the swagman having corks dangling from his old felt hat. In the summer months, the flies caused much infection of the eyes, especially amongst the children, and a routine daily eye drill was being carried out at the school.

My three months went very quickly and I was sorry that my stay could not be longer.

I found the people of the outback hospitable and friendly. One is taken very much on one's face value. It is impossible to stand on dignity. The country is big and one must be big in every sense.

I made the 600 mile train journey north into what is known as the ' Red Heart ' of Australia to Alice Springs where I saw the receiving end of the Flying Doctor Service in action at the Alice base. Alice is a small, pleasant town which has grown in the past ten years into a centre for winter tourists. Its summer temperature is well over the hundred.

The Rev. J. Flynn (' Flynn of the Inland ') of the Australian Inland Mission did much of his work in Alice and today there is a very modern church, known as the Flynn Memorial Church, to his memory.

The two cinemas in Alice are both in the open, and it was most leisurely to sit back in a deck chair under the stars and watch the screen.

I flew back a thousand miles from Alice Springs to Adelaide in four hours; and then spent three months in two small hospitals in Victoria.

One was a small maternity hospital of 15 beds. This was very well equipped. All mothers are delivered in hospital, and normal cases go home on the tenth day.

Mothers are invited to attend the infant welfare centre. These centres are staffed by baby health nurses (similar to our health visitors, except that they undertake very little home visiting). The baby health nurse visited the hospital each week and saw the mothers before discharge which I thought was an excellent idea.

I visited Sydney and Melbourne, both modern and excellent cities. At the Nurses Memorial Centre in Melbourne one can stay for as little as 25s. bed and breakfast. It was built and equipped as a memorial to Australian Nurses who gave their lives in the 1939–45 War. I spent a very happy time there and met several other U.K. Nurses who were also passing through Melbourne.

I sailed home on the ' Orcades ' via the Suez Canal, after a most interesting and stimulating year " down under ".

CLASSIFIED ADVERTISEMENTS

Advertisements for this section can be received up to first post on the 2nd of the month for publication on the 10th. They should be sent direct to: District Nursing, 57 Lower Belgrave Street, London, S.W.1. Telephone Sloane 0355.
Rates: Personal, 2½d. per word (minimum 12 words, 2s. 6d.): all other sections, 3d. per word (minimum, 12 words 3s.)
Displayed Setting: 17s. 6d. per single column inch.

APPOINTMENTS

NORFOLK COUNTY COUNCIL

Applications are invited for vacancies in the under mentioned areas:

District Nurse/Midwife/Health Visitor (preferably with Queen's and H.V. Certificate or willing to train).

Aldeby, Nr. Beccles. Unfurnished house. **Burnham Market,** North Norfolk. Unfurnished house. **Castle Rising,** Nr. King's Lynn. **Hillington,** Nr. King's Lynn. Two nurses (friends) required for double district. Unfurnished bungalow at Flitcham. **Hockham,** Nr. Thetford. Unfurnished house. **Nordelph,** Nr. Downham Market. Unfurnished house. **Oulton,** Nr. Aylsham. Unfurnished house. **Southery,** Nr. Downham Market. Unfurnished bungalow. **Tilney,** Nr. King's Lynn. Unfurnished house. **Terrington St. John,** Nr. King's Lynn. Furnished accommodation—house later.

District Nurse/Midwife (preferably with Queen's Certificate or willing to train).

Diss. Unfurnished house. **Fakenham.** Increase of staff. One of three nurses living separately. Furnished accommodation.

Full-time Midwife.

East Dereham. Unfurnished house.

Facilities available for Health Visitor and Queen's Nurse training with a view to generalised duties.

Staff needed for relief duties—holidays or longer periods.

Whitley Council salaries and conditions of service.

Successful applicants can use their own cars (loans available for purchase) or cars can be provided.

Application forms from County Medical Officer, 29 Thorpe Road, Norwich.

BUCKS COUNTY COUNCIL

Midwifery and Home Nursing Service

Aylesbury. One District Nurse/Midwife. Self-contained flat available, furnished or unfurnished. Car driver or willing to learn. **Haddenham.** One District Nurse/Midwife, Rural Area. Cottage available, furnished or unfurnished. Car driver essential. **St. Leonards.** One District Nurse/Midwife, Rural Area. Bungalow available, furnished or unfurnished. Car driver essential. **Linslade.** One District Nurse/Midwife. House available, furnished or unfurnished. Car driver or willing to learn. **Woburn Sands.** One District Nurse/Midwife/Health Visitor for generalised work in rural area. Standard nurse's house available, furnished or unfurnished. Car driver essential.

Apply: County Medical Officer, County Offices, Aylesbury, Bucks.

SOMERSET COUNTY COUNCIL

Midwifery and Nursing Services
Whitley Council Conditions

Peasedown St. John (Nr. Bath)
Two Queen's Nurse/Midwives with Health Visitors certificate or willing to train. Two cars provided. Small furnished house.

Lower Langford
Double vacancy for Queen's Nurse/Midwives with Health Visitors certificate or willing to train. Attractively furnished house. Two cars available.

Langport Area
S.R.N., S.C.M. required for relief duties in group of three. Unfurnished bungalow available. Car provided.

Clevedon
Queen's Nurse/Midwife, or S.R.N., S.C.M., to work in group of four. Car provided. Lodgings available.

Crewkerne
Two Queen's Nurse/Midwives with Health Visitors certificate or willing to train. To live in comfortably furnished house. Two cars provided. Third Queen's Nurse/Midwife employed, living separately.

Frome
Nurse/Midwife urgently required to work with group of five nurses. Comfortable attractive home.

Keynsham
Two Nurse/Midwives urgently required. Motorists. Attractive furnished flat available for one and, if necessary, help given in securing accommodation for second appointment.

Bridgwater
Full-time S.R.N. required, preferably with district training; or an experienced S.E.A.N. Motorist. Resident in comfortable nurses' home or non-resident.

Help given with driving tuition in all cases, if required.

For further particulars apply to: County Medical Officer of Health, County Hall, Taunton.

CITY OF YORK

District Midwife and Premature Baby Nurse
Applications are invited from State Certified Midwives for two district posts in the City of York:—

1. Premature baby nurse—vacant January 1st, but training if necessary will be arranged before that date.
2. District midwife.

Whitley Council Salary and conditions of service. Car allowance available.

Applications stating age, qualifications and experience, together with the names of two referees, to be forwarded to the Medical Officer of Health, 9 St. Leonard's Place, York.

T. C. BENFIELD
Town Clerk

CORPORATION OF THE CITY OF ABERDEEN

HEALTH AND WELFARE DEPARTMENT

Centre Superintendent Health Visitor

Applications are invited for the above-named post from health visitors with experience of, or interest in, clinic administration and group teaching. The person appointed will be expected to take charge of one of the Corporation's Clinics and to take part in the group teaching undertaken by the Health Guidance section of the Health and Welfare Department, such teaching including some evening work. The salary (at present £30 above the ordinary health visitor scale) and conditions of service are in accordance with the recommendations of the Nurses and Midwives Whitley Council.

Further information and forms of application may be obtained from the Medical Officer of Health, Willowbank House, Willowbank Road, Aberdeen, to whom applications should be sent within 14 days of the appearance of this advertisement.

J. C. Rennie, Town Clerk, Town House, Aberdeen.

THE GLASGOW DISTRICT NURSING ASSOCIATION

Affiliated with the Queen's Institute of District Nursing Scottish Branch

Applications are invited from experienced Queen's Nursing Sisters for the post of Superintendent of the Training Home at 218 Bath Street (resident). Applicants should hold the Health Visitor's Certificate and have had experience in administration. District Nurse Tutor employed. The Home is recognised for Part II Midwifery Training.

The appointment will be subject to the Local Authority Superannuation Scheme and the successful candidate will be required to pass a medical examination.

Salary and conditions of service in accordance with the Whitley Council recommendations.

Applications should be received not later than Monday, 22nd September, 1958 by Moores, Carson & Watson, Chartered Accountants, 209 West George Street, Glasgow, C.2.

ST. HELENS DISTRICT NURSING ASSOCIATION

First Assistant Superintendent required. H.V. Certificate preferred. Post provides experience in general administration and in the training of Student District Nurses. Motorist or willing to learn. Accommodation provided in comfortable well equipped home.

Apply: Dep. Gen. Supt., Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

Other Advertisements on p.148

EXETER—DEVON
(Training Home)

Second Assistant Superintendent required (resident) Health Visitor's Certificate. Interested in practical teaching and in general administration. Previous experience not essential. Motorist—car provided or allowance to car owner.

Apply, Superintendent, Exeter Maternity and D.N.A., 11 Elmgrove Road, Exeter.

ST. HELIER, JERSEY

Two Queen's Nurses/Midwives required, one to act as Senior Nurse. Staff consists of three full time nurses (including Senior) and two part-time. General nursing, midwifery and school work undertaken. Car and bicycles provided. Furnished flat available.

Apply: Dep. Gen. Supt., Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

BRIGHTON D. N. A.

First Assistant Superintendent required. Excellent experience in general administration. General nursing and little midwifery undertaken. Staff approximately 39 including Student District Nurses. Motorist, car provided or allowance for owner user. Resident or non resident.

Apply: Dep. Gen. Supt., Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

QUEEN'S INSTITUTE OF DISTRICT NURSING

There are opportunities for Queen's Nurse/Midwives/Health Visitors as ASSISTANT SUPERINTENDENTS to gain experience in the training of pupil midwives and district nurses and in administration in preparation for posts of responsibility at home and abroad. Enquiries should be addressed to:- Deputy General Superintedent, Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

HEALTH VISITOR

JERSEY Queen's Nurse with H.V. Cert: required for full-time Health Visiting Duties. Furnished flat and car provided.

Apply: Dep. Gen. Supt., Q.I.D.N., 57 Lower Belgrave Street, London, S.W.1.

QUEEN'S NURSES' BENEVOLENT FUND

Annual Meeting and Bring and Buy Sale Saturday, October 4th 1958, at 3 p.m. at **Hackney District Nursing Association,** 6 Lower Clapton Road, London, E.5.

Please give your support to this effort, which had to be postponed in June.

Miss Ironside, Superintendent of Hackney D.N.A., will be pleased to receive your gifts for the Bring and Buy Sale if you cannot attend personally.

REPLACEMENT OF THE ENEMA

AN article in a recent British Medical Journal* is one which might have important repercussions throughout the nursing world. This paper deals with a new type of laxative substance (4, 4'—diacetoxydiphenyl)—(pyridyl-2)-methane), " Dulcolax " in a suppository form which was successfully used to replace enemata in old patients.

During a period of one month in four wards at the Geriatric Unit, St. James's Hospital, Leeds, there were 155 occasions when enemata would have been given. Instead of the traditional treatment, however, Dulcolax suppositories were used. It was found that in 131 instances an excellent result was obtained following the use of only one suppository. In a further twelve instances, two suppositories were necessary and on the remaining twelve occasions the use of a nocturnal aperient followed by a suppository in the morning brought about a satisfactory result. Thus, by a combination of dosages enemata were dispensed with entirely. Of great importance too was the fact that the occurrence of side effects was negligible so that from the patient's point of view very little discomfort was experienced to obtain a result which previously had necessitated an uncomfortable and often objectionable procedure.

As far as the nurse is concerned the use of Dulcolax suppositories to supercede enemata, has many advantages of course. Quite apart from any aesthetic considerations there is a great saving of time and the need for changing and sluicing of bed linen is greatly reduced, whilst the morale of patients, particularly the bedridden elderly, is raised, allowing easier management in many cases.

A point of further significance which emerges from this trial of Dulcolax is that, in the majority of patients, a response was evident within one hour of the insertion of the suppository. Only just over a third of the patients experienced a bowel movement after sixty minutes.

By implication, the replacement of all enemata for any particular purpose is foreshadowed by the results obtained by Dr. Clark. Thus, the use of enemata pre- and post-operatively can be substituted by treatment with Dulcolax. In radiology too, the use of enemas where necessary can be avoided and Dulcolax treatment instituted. In these two latter indications the use of Dulcolax tablets will act as adjuvant to complete bowel clearance, where this is necessary for surgical or pre-radiological treatment.

It will indeed be a major advance if the procedure adopted by Dr. Clark and all its implications form a part of routine nursing practice for the future. The enema has never been beloved either by patient or nursing staff and any method of bowel clearance which is effective and unobjectionable will, no doubt, receive the acclaim of both nurse and patient alike.

C. R. Dimond, M.P.S., D.B.A.

**Brit. Med. J. (1957), 2: 866.*

JENNY COMES HOME

MIDWIVES, health visitors and district nurses who are interested in the teaching of parent-craft will find the film *Jenny Comes Home*, a useful visual aid.

The film has been produced by Eothan Films at St. Thomas's Hospital, London, with the co-operation of the Royal College of Midwives and sponsored by Johnson and Johnson, Ltd.

The commentary is spoken by Jean Metcalfe.

The young mother and baby are first seen in hospital during the first days of the puerperium. The mother's fears about caring for her baby on return home are well described. These fears are dispelled as the mother is taught by the Sister how to feed, bath, dress and generally handle her baby.

We are then shown the family in their own home with the mother and father caring for and enjoying their lovely daughter at the age of five months.

Public health nurses may not agree with all the techniques used in the film but would nevertheless find it useful for teaching groups of young parents, student nurses, pupil midwives and older school girls.

Jenny Comes Home is a 3-reel, 16 m.m. film in technicolour, available on free loan from Johnson and Johnson (Great Britain) Ltd., Slough, Bucks. **R.A.B.**

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